Clinical Utilization Review Board (CURB)
Meeting Minutes
May 20, 2015

PRESENT:
Board: Michel Benoit, MD, David Butsch, MD, Ann Goering, MD, Jessica MacLeod, NP, Paul Penar, MD, Norman Ward, MD

DVHA Staff: Daljit Clark, Jennifer Herwood, Susan Mason, Megan Mitchell, Thomas Simpatico, MD (moderator), Scott Strenio, MD, Bradley Wilhelm

Guests: Madelyn Mongan, Lisa Schilling

Absent: Delores Burroughs-Biron, MD, John Matthew, MD, Richard Wasserman, MD

HANDOUTS

- Agenda
- Draft minutes from 3/18/2015 Meetings

CONVENE: Dr. Thomas Simpatico convened the meeting at 6:30 pm.

1.0 Introductions

2.0 Review and Approval of Minutes

The minutes from 3/18/2015 meeting were approved as written.

3.0 Updates

New CURB Members
New CURB member Jessica MacLeod, NP introduced herself to the group. Dr. Simpatico announced that Dr. Minsinger has resigned his position on the board. Dr. Minsinger has served since October, 2010.

Conflict of Interest
Bradley Wilhelm, DVHA attorney will be working on a conflict of interest policy for Clinical Utilization Review Board (CURB) and Drug Utilization Review Board (DURB). The purpose of this policy is to legitimize decisions made by the boards. He will be working with Howard Pallotta, DVHA General Counsel to draft policies and guidelines and processes for conflict of interest policies.

Dashboard Proposal
Dr. Strenio presented that DVHA is working on a dashboard which would track utilization to identify trends. DVHA identified issues that has come to their attention, but this will help to have a real-time sense of what is happening and to be able to show CURB the trending data to help inform discussions. The dashboard

will drill down to regional parts of the state. It is unclear how this information will be disseminated to the public. We want to measure ourselves against national and regional benchmarks. We also want to standardize the data including comparison of VT Medicaid data to other Medicaid's. We have just started outlining the process with DVHA's Information Technology Department and are hoping for the first version of the dashboard this summer. We can use the dashboard to track the impact of CURB decisions.

90853 Proposal

The DVHA Commissioner signed off on CURB's recommendation to bring the CPT Code 90853 into compliance with the National Correct Coding standards. The recommendation is posted for public comment until June 15, 2015. The effective date of implementation is July 1, 2015.

4.0 New Business

Psychotherapy Proposal

What is meant by Psychotherapy?

It involves techniques that help people manage their symptoms better. It helps with symptoms management and works with medication or alone depending on the person and their issues.

There are different disciplines of psychotherapy:
Cognitive Behavioral Therapy (CBT) - focuses on thoughts and beliefs and how they influence moods and actions. This blends cognitive therapy with behavioral therapy.

Dialectical Behavioral Therapy (DBT) – emphasizes tension between two new opposing views to create a logical compromise. It is effective with borderline personality care.

Supportive Psychotherapy – Most of what we pay for is supportive therapy to support people in their problem-solving.

Dr. Simpatico presented data on adults and children and the how much VT Medicaid pays for outpatient psychotherapy services.

Per the standard deviation bell curve, roughly 65% of adults and children get 0-13 visits/year, 20% get 14-26 visits, 17% get 27-60 sessions and 2% get 60 plus sessions a year.

Some other states and private insurers limit visits for outpatient psychotherapy, some don't. Some have a prior authorization requirement (PA) but some do not PA.

We could choose to:

1) **Do nothing for a certain number of visits**
2) **Ask for some additional information from the provider that isn't onerous (i.e. diagnosis modality) for a certain number of visits**
3) **Or require prior authorization (PA)**

ICD-10 will begin in October, 2015. The ICD-10 codes will give us more specific information for the psychotherapy codes.

There is no evidence for providing psychotherapy for depression; there is evidence for CBT for depression. We don't know what we are paying for.

If we tighten the rules, does this change the number of providers? How can we help our provider base become more rigorous in their treatment?

We don't want to push people out of the supporting environment and end up sending them to the Department of Corrections (DOC) or into the Emergency Room (ER).

Questions:
Under the banner of psychotherapy, what are the treatment modalities being provided and who is providing these services?
Should we also look at psychological pharmacology use, including how medication possession ratios are determined?
Can we look at the data by diagnosis?
Should we look at ER use and inpatient hospital admission rates?
Benchmarking against other states would be very useful.

The high utilizers in mental health tend to be the same individuals year over year. We could track this population over an extended period of time. Once we identify the population we can look at all the other costs of these individuals.

How can we correlate what the Pharmacy Benefit Manager (PBM) can get in the implication of Medication Possession Ratio (MPR) and this population?

Action Item #1: Present the past CURB initiatives, including the gold card for Radiology services, and how much they have saved the State of Vermont.

Adjournment – CURB meeting adjourned at 8:10 PM

Next Meeting

July 8, 2015
Time: 6:30 PM – 8:30 PM
Location: Department of Vermont Health Access, Williston, VT